Triage Note [redacted]

* Final Report *

Result date: 30 October 2012 16:05 EDT
Result status: Auth (Verified)

* Final Report *

ED Triage Entered On: 10/30/2012 16:09 EDT
Performed On: 10/30/2012 16:05 EDT by [redacted]

Assessment I
Chief Complaint : patient from ecf with altered ms, hallucinating/confused. multiple falls. trached patient. HD patient, has g-tube. low grade fevers.
IV Field Start : Yes
Affect/Behavior : Calm
Pain Scale Type : 0-10 Pain scale
Primary Pain Intensity : 8
Allergies Reviewed : Yes
Oxygen Therapy : Trach collar
Temperature Tympanic : 99.8DegF(Converted to: 37.7DegC)
Peripheral Pulse Rate : 115bpm (HI)
Respiratory Rate : 22br/min (HI)
Systolic Blood Pressure : 160mmHg (>HHI)
Diastolic Blood Pressure : 90mmHg
SpO2 : 96%
Oxygen Flow Rate : 10L/min
Dosing Weight : 94kg(Converted to: 207lb 4oz, 207.235lb)
(R) Patient Weight : Stated
Height : 69inch(Converted to: 5ft 9inch, 175.26cm, 5.75ft)

[redacted]

Assessment II
Pregnancy Status : N/A
Fall Risk Order Detail : Yes
Languages : English

[redacted]

Dx Control/PMH
Triage Reason for Visit : Yes

[redacted]

(As Of: 10/30/2012 16:09:28 EDT)

Problems(Active)
Tracheostomy tube

[redacted]

Diagnoses(Active)

[redacted]

Triage Note

[redacted]

* Final Report *

Altered mental status

Date: 10/30/2012 ; *Diagnosis Type:* Reason For Visit ; *Confirmation:* Complaint of ; *Clinical Dx:* Altered mental status ; *Classification:* Present On Admission ; *Clinical Service:* Emergency medicine ; *Code:* SNOMED CT ; *Probability:* 0 ; *Diagnosis Code:* 2576783013

ESI

Requires immediate life-saving interventions? : No
Is this a high risk situation?
Consider AVPU score. : Yes
ESI recommended level : 2
ESI clinical agreement : Yes

[redacted]

DCP GENERIC CODE

Tracking Specialty : Main ED
Tracking Acuity : 2
Tracking Group : ED Tracking Group

[redacted]

Allergy

(As Of: 10/30/2012 16:09:28 EDT)

Allergies (Active)

NKA

Estimated Onset Date: Unspecified ; *Created By:* [redacted] *Reaction Status:* Active ; *Category:* Drug ; *Substance:* NKA ; *Type:* Allergy ; *Updated By:* [redacted] *Reviewed Date:* 10/28/2012 10:57 EDT

[redacted]

ED Note-Physician

[redacted]

Result date: 30 October 2012 19:22 EDT
Result status: Auth (Verified)

Fever

[redacted]

Attachments: **None**
Associated Diagnosis: Fever 780.60; Urinary tract infection 599.0; Septicemia 038.9

Basic Information

Time seen: Date & time 10/30/2012 19:23:00.
History source: Patient.
Arrival mode: Private vehicle.
History limitation: None.
Additional information: Chief Complaint from Nursing Triage Note : Chief Complaint.
10/30/2012 16:05 EDT Chief Complaint patient from ecf with altered ms, hallucinating/confused. multiple falls. trached patient. HD patient, has g-tube. low grade fevers.

History of Present Illness

The patient presents with fever. The onset was 2 days ago. The course/duration of symptoms is fluctuating in intensity. Associated symptoms: weakness. Temperature is subjective. Risk factors consist of dialysis patient, S/P G tube and HTN ETOH, Pancreatitis. Prior episodes: frequent. Therapy today: Acetaminophen.

Review of Systems

Constitutional symptoms: Fever.
Skin symptoms: Negative except as documented in HPI.
Eye symptoms: Negative except as documented in HPI.
ENMT symptoms: Negative except as documented in HPI.
Respiratory symptoms: Cough.
Cardiovascular symptoms: Negative except as documented in HPI.
Gastrointestinal symptoms: Negative except as documented in HPI.
Genitourinary symptoms: Negative except as documented in HPI.
Musculoskeletal symptoms: Negative except as documented in HPI.
Neurologic symptoms: Negative except as documented in HPI.
Psychiatric symptoms: Negative except as documented in HPI.
Endocrine symptoms: Negative except as documented in HPI.
Hematologic/Lymphatic symptoms: Negative except as documented in HPI.

Health Status

Allergies: .
Allergic Reactions (All)
NKA

Past Medical/ Family/ Social History

Surgical history: .
Tarsal tunnel (32945011) in 2008 at 51 Years.
History of knee surgery (2692296016) in 1982 at 25 Years.
Cholecystectomy (64698015).
History of tonsillectomy (2790280011).
Comments:
10/06/2011 14:50 - [redacted]
1985 does know specific dates

Family history: .
No family history items have been selected or recorded.

[redacted]

Social history: Alcohol use: Occasionally.

Physical Examination

Vital Signs

Vital Signs.

10/30/2012 18:58 EDT **Peripheral Pulse Rate 109 bpm HI**
Respiratory Rate 20 br/min
Systolic Blood Pressure 152 mmHg >HHI
Diastolic Blood Pressure 105 mmHg >HHI
SpO2 98 %
10/30/2012 17:05 EDT **Peripheral Pulse Rate 109 bpm HI**
Respiratory Rate 20 br/min
Systolic Blood Pressure 154 mmHg >HHI
Diastolic Blood Pressure 90 mmHg
Mean Arterial Pressure 111.333 mmHg
SpO2 100 %
FiO2 50 %
10/30/2012 16:26 EDT Temperature Rectal 100.0 DegF
10/30/2012 16:05 EDT Temperature Tympanic 99.8 DegF
Peripheral Pulse Rate 115 bpm HI
Respiratory Rate 22 br/min HI
Systolic Blood Pressure 160 mmHg >HHI
Diastolic Blood Pressure 90 mmHg
SpO2 96 %

Measurements.

10/30/2012 17:05 EDT Height 69 inch
Patient Weight Stated
BSA 2.14
Body Mass Index 31 m2
Dosing Weight 94 kg
10/30/2012 16:05 EDT Height 69 inch
Patient Weight Stated
Dosing Weight 94 kg

Basic Oxygen Information.

10/30/2012 19:19 EDT Chart Annotations update
10/30/2012 18:58 EDT **Peripheral Pulse Rate 109 bpm HI**
Respiratory Rate 20 br/min
Systolic Blood Pressure 152 mmHg >HHI
Diastolic Blood Pressure 105 mmHg >HHI
SpO2 98 %
Oxygen Therapy Trach collar
10/30/2012 18:15 EDT Chart Annotations update
10/30/2012 18:09 EDT Reg Antithrombotic By End of Day 2 Goal Met
Reg STK Antithrombotic by End Day 2 Yes
10/30/2012 18:09 EDT acetaminophen 650 mg mg
10/30/2012 18:05 EDT Chart Annotations Urine
10/30/2012 18:04 EDT WBC 6.8 thous/mm3
RBC 3.18 mill/mm3 LOW
HGB 8.8 g/dL LOW
HCT 26.6 % LOW

MCV	83.7 fL
MCH	27.7 pg
MCHC	33.1 g/dL
RDW	**16.3 % HI**
Platelet	351 thous/mm3
MPV	7.5 fL
Gran %	**69.4 % HI**
Lymph %	**18.9 % LOW**
Mono %	**11.1 % HI**
Eos %	0.3 %
Baso %	0.3 %
Gran #	4.7 thous/mm3
Lymph #	**1.3 thous/mm3 LOW**
Mono #	0.8 thous/mm3
Eos #	0.0 thous/mm3
Baso #	0.0 thous/mm3
Lactic Acid	1.0 mmol/L
UA Spec Grav	1.013
UA pH	7.0
UA Leuk Est	**Large**
UA Nitrite	Negative
UA Protein	**30 mg/dl**
UA Ketones	Negative
UA Glucose	Negative
UA Bili	Negative
UA Urobilinogen	0.2 mg/dL
UA Blood	**Small**
UA WBC/hpf	**>100**
UA RBC/hpf	**2-5**
UA Squam Epithelial	Rare
UA Bacteria	**Many**
UA Mucous	Few
Influenza A Ag	Neg
Influenza B Ag	Neg
Source Flu A&B	**Nasopharyngeal**

10/30/2012 17:42 EDT 20 gauge Peripheral saline lock Left Hand

Field Start Date:	10/30/2012 17:42
PIV Started at Other Facility:	No
Peripheral IV Activity:	Assess
Peripheral IV Site Condition:	No complications
Peripheral IV Drainage Description:	None
Peripheral IV Dressing:	Dry, Intact, Transparent
Peripheral IV Patency:	Flushed/No complications, Good blood return
Peripheral Line Saline Flush:	10 mL

20 gauge Peripheral saline lock Left Arm

IV Start Date:	10/30/2012 17:43
PIV Started at Other Facility:	No
Peripheral IV Activity:	Start
Peripheral IV Drainage Description:	None
Peripheral IV Dressing:	Dry, Intact, Transparent

Peripheral IV Patency: Flushed/No complications, Good blood return
Peripheral Line Saline Flush: 10 mL
10/30/2012 17:19 EDT ED Note-Nursing (Modified)
10/30/2012 17:05 EDT Height 69 inch
Patient Weight Stated
BSA 2.14
Body Mass Index 31 m2
Dosing Weight 94 kg
Peripheral Pulse Rate 109 bpm HI
Respiratory Rate 20 br/min
Systolic Blood Pressure 154 mmHg >HHI
Diastolic Blood Pressure 90 mmHg
Mean Arterial Pressure 111.333 mmHg
SpO2 100 %
FiO2 50 %
Pain Scale Type FLACC Scale
Pain Score- Face 0- No particular expression or smile
Pain Score- Legs 0- Normal position or relaxed
Pain Score- Activity 0- Lying quietly, normal position, or moves easily
Pain Score- Cry 0- No cry (awake or asleep)
Pain Score- Consolability 0- Content, relaxed
Head & Neck Assessment PF Assessment norms met
Head & Neck Assessment Norms Area is free from bony deformities, facial expression is sym, No bony depressions/crepitus, Normal eye and eyelid position, Normal ear position, No drainage or bleeding, No periorbital edema, No ecchymosis or bruising, Normal EOM

Cardiovascular Assessment PF Exceptions noted
Cardiovascular Symptoms Edema
Nail Bed Color Pink
Capillary Refill < 3 seconds
Heart Rhythm Regular
Radial Pulse, Left 2+ Normal
Radial Pulse, Right 2+ Normal
Dorsalis Pedis Pulse, Left 2+ Normal
Dorsalis Pedis Pulse, Right 2+ Normal
Edema Localized
Edema, Left Pretibial 2+ mild/4mm
Edema, Right Pretibial 2+ mild/4mm
Edema, Left Ankle 2+ mild/4mm
Edema, Right Ankle 2+ mild/4mm
Edema, Left Pedal 2+ mild/4mm
Edema, Right Pedal 2+ mild/4mm
Edema, Left Lower Leg 2+ mild/4mm
Edema, Right Lower Leg 2+ mild/4mm
Cardiac Rhythm Sinus tachycardia
Respiratory Assessment PF Exceptions noted
Respirations Shallow, Other: PT HAS TRACH
Respiratory Pattern Description Regular
Breath Sounds Auscultated Anterior and posterior
Lung Sounds Left Rhonchi

Lung Sounds Right Rhonchi
Left Upper Lobe Breath Sounds Rhonchi
Right Upper Lobe Breath Sounds Rhonchi
Right Middle Lobe Breath Sounds Rhonchi
Left Lower Lobe Breath Sounds Rhonchi
Right Lower Lobe Breath Sounds Rhonchi
All Lobes Breath Sounds Rhonchi
Cough Non-Productive
Sputum Color Other: WHITISH GREEN
Oxygen Therapy Trach collar
GI Assessment PF Exceptions noted
GI Symptoms Incontinence, Other: G-TUBE: UNABLE TO AUSCULTATE WHEN PLACEMENT CHECKED, DO NOT USE UNTIL PLACEMENT VERIFIED.
Abdomen Palpation Non-Tender, Soft
Bowel Sounds LUQ Present
Bowel Sounds RUQ Present
Bowel Sounds LLQ Present
Bowel Sounds RLQ Present
GU Assessment PF Exceptions noted
Urinary Symptoms Incontinence
Pregnancy Status N/A
Lactating N/A
Musculoskeletal Assessment Assessment norms met
Musculoskeletal Assessment Norms No orthopedic devices, No joint or musculoskeletal abnormalities, Full range of motion
Integumentary Assessment PF Exceptions noted
Skin Color Pink
Skin Temperature Warm
Skin Turgor Elastic
Mucous Membrane Color Pink
Skin Abnormality Present Yes
Incision/Wound, Ulcer, Skin Tear Present Yes
Surgical drains/tubes present Yes
Skin Abnormality/Location Grid Skin Abnormality/Location Grid
I/W Present on Admission-Site A Yes
Site A Healed No
Incision/Wound Type-Site A Other: WOUND
Incision/Wound Location-Site A Ankle, right
Incision/Wound Length-Site A 6.5 cm
Incision/Wound Width-Site A 6 cm
Length x Width Site A 0 cm
Incision/Wound Surrounding Tissue-Site A Healthy/Intact
I/W Pink Color Percentage-Site A 100%
Incision/Wound Dressing-Site A Intact, Apply, Changed
I/W Present on Admission-Site B Yes
Site B Healed No
Incision/Wound Type-Site B Other: WOUND
Incision/Wound Location-Site B Knee, left
Incision/Wound Length-Site B 2.2 cm
Incision/Wound Width-Site B 2.2 cm
Incision/Wound Depth outlier-Site B Depth is <0.25 cm

Length x Width Site B < 0.3 cm
Incision/Wound Surrounding Tissue-Site B Callous
I/W Black Color Percentage-Site B 30%
I/W Pink Color Percentage-Site B 50%
I/W Yellow Color Percentage-Site B 20%
Incision/Wound Dressing-Site B Intact, Apply, Changed
Neuro Assessment PF Exceptions noted
Neurological Symptoms Confusion/Disorientation
Gait Unable to assess
Extremity Movement Equal
Characteristics of Speech Clear
Facial Symmetry Symmetric
Level of Consciousness Alert
Loss of Consciousness Unknown
Hallucinations Present Auditory hallucinations, Visual hallucinations
Eye Opening Response Glasgow Spontaneously
Best Motor Response Glasgow Obeys simple commands
Best Verbal Response Glasgow Confused (Modified)
Glasgow Coma Score 14 (Modified)
Pupil Description, Left Regular
Pupil Descriptions, Right Regular
Pupil Reaction, Left Brisk
Pupil Reaction, Right Brisk
LUE Strength 4 moves against some resistance
RUE Strength 4 moves against some resistance
LLE Strength 4 moves against some resistance
RLE Strength. 4 moves against some resistance
LUE Tone Normal
RUE Tone Normal
RLE Tone Normal
RUE Sensation Intact
LLE Sensation Intact
RLE Sensation Intact
Affect/Behavior Calm
Orientation Assessment Not oriented to place, Not oriented to time
Feels Safe at Home? Unable to assess
Depression Medical History Yes
Reg Cigarette Smoking Last 365 Days No
Skin Breakdown Risk Triage Yes
FLACC Pain Scale FLACC Scale
Tobacco Use Never
ED Assessment Adult Form ED Assessment Adult Form (Modified)
ED Assessment - Nurse ED Assessment Adult (Modified)

10/30/2012 16:26 EDT Temperature Rectal 100.0 DegF
Vital Signs Form Vital Signs Form
10/30/2012 16:23 EDT ED Note-Nursing initial (In Progress)
10/30/2012 16:05 EDT Reg STK Adm Elective Carotid Intervent No
Reg VTE Surgical Patient No
Reg VTE ICU Surgical Patient No
Reg VTE Present on Arrival No
10/30/2012 16:05 EDT Reg PN Clinical Trial vA No

Reg SC Clinical Trial No
Reg STK Clinical Trial No
Reg VTE Relevant Clinical Trial No
10/30/2012 16:05 EDT Reg AMI Relevant Clinical Trial vA No
Reg HF Relevant Clinical Trial No
10/30/2012 16:05 EDT Chief Complaint patient from ecf with altered ms, hallucinating/confused. multiple falls. trached patient. HD patient, has g-tube. low grade fevers.
Height 69 inch
Patient Weight Stated
Dosing Weight 94 kg
Temperature Tympanic 99.8 DegF
Peripheral Pulse Rate 115 bpm HI
Respiratory Rate 22 br/min HI
Systolic Blood Pressure 160 mmHg >HHI
Diastolic Blood Pressure 90 mmHg
SpO2 96 %
Primary Pain Intensity 8
Pain Scale Type 0-10 Pain scale
Oxygen Therapy Trach collar
Oxygen Flow Rate 10 L/min
Pregnancy Status N/A
Affect/Behavior Calm
Languages English
IV Field Start Yes
ESI life-saving interventions needed No
ESI high risk situation/AVPU score eval Yes
ESI recommended level 2
ESI clinical agreement Yes
Tracking Group ED Tracking Group
Tracking Acuity 2
Allergies Reviewed Yes
Fall Risk Order Detail Yes
ED Triage Form ED Triage Form
Triage Note ED Triage

General: Alert.
Skin: Warm.
Head: Normocephalic.
Neck: Trachea midline.
Eye: Normal conjunctiva.
Ears, nose, mouth and throat: dry mucus membrane.
Cardiovascular: Regular rate and rhythm.
Respiratory: Lungs are clear to auscultation.
Chest wall: No tenderness.
Back: Nontender.
Gastrointestinal: Soft, Nontender, Non distended, Normal bowel sounds and No organomegaly.
Genitourinary: No tenderness.
Neurological: Alert and oriented to person, place, time, and situation.
Lymphatics: No lymphadenopathy.
Psychiatric: Cooperative.

Medical Decision Making

Differential Diagnosis: Fever, Urosepsis.
Rationale:+ grossly infected urine, will give abx and admit. G tube in place.

Impression and Plan

Diagnosis

Fever 780.60 - Emergency medicine, Medical
Urinary tract infection 599.0 - Emergency medicine, Medical
Septicemia 038.9 - Emergency medicine, Medical

Plan

Notes: sick appearing infected urine, will check labs and admit. CXr negative.

Result date: 31 October 2012 0:13 EDT
Result status: Auth (Verified)

* Final Report *

HISTORY AND PHYSICAL

Estimated Arrival Date:
Admit Date: 10/30/12
Registration Date: 10/30/12

HISTORY OF PRESENT ILLNESS:
[redacted] is a 55-year-old male with a history of rhabdomyolysis secondary to being found down approximately four months ago with the development of end-stage renal disease secondary to rhabdomyolysis and also initiated on arctic sun since he was found down and resuscitated who was discharged from Waterbury Hospital two weeks ago and returns from [redacted] with altered mental status, fever, and hallucinations. Per the W-10 from [redacted] the patient was sent to the emergency room recently with hypokalemia and returned but has had mental status changes that have been declining since, and the patient was very confused, hallucinating, and developed low grade temperatures. In the emergency room the patient was found to be febrile to 100, tachycardic to 110, with a respiratory rate of 22, and a urinalysis that showed large leukocyte esterase and greater than 100 WBC's. The patient was given ceftriaxone IV times one and was admitted to the floor.

PAST MEDICAL HISTORY:
Alcohol abuse.
Hypertension.
Depression.
Pancreatitis.
Sleep apnea.
Appendectomy.
Cholecystectomy.
Ulcerative colitis.
End-stage renal disease secondary to rhabdomyolysis with hemodialysis on Tuesday, Thursday, Saturday.
Methicillin sensitive staph aureus bacteremia.

MEDICATIONS:
The patient is on Lisinopril 40 mg by mouth daily.
Metoprolol 37.5 mg by mouth twice daily.
Multivitamin one tab daily.
Pantoprazole 40 mg by mouth daily.

Water bolus 150 cc every eight hours through G-tube.
Tube feeds with Jevity 1.0 60 cc an hour from 10:00 p.m. to 4:00 p.m. for a total of 18 hours.
Milk of Magnesia 30 mL by mouth every day as needed for no bowel movement in three days.
Bisacodyl suppository one suppository per rectum daily as needed for no bowel movement if Milk of Magnesia is ineffective.
Fleet enema one enema per rectum daily as needed for no bowel movement if bisacodyl is ineffective.
Tylenol 650 mg by mouth every four hours as needed for discomfort or temperature.
Tylenol 650 mg suppository per rectum every four hours as needed for discomfort or temperature.
Vicodin one tab by mouth every four hours as needed for pain.
Codeine promethazine 10 / 6.25 per 5 mL of syrup 5 mL every six hours as needed for cough.
Methanol topical one throat lozenge oral every two hours as needed for sore throat.
Lexapro 10 mg by mouth daily.
Natural Tears two drops to both eyes at night.
Heparin 5,000 units every eight hours subcutaneously.
Albuterol nebulizer 0.63 mg three times daily.
Ferrous sulfate 300 mg per 5 mL, 5 mL three times daily.
Sevelamer 2.4 grams by mouth three times daily.
Flomax 0.4 mg by mouth daily.
Cymbalta 60 mg by mouth daily.
Folic acid 1 mg by mouth daily.
Midodrine two tabs by mouth one time per day as needed.
Ambien 5 mg by mouth at night as needed for insomnia.
Morphine 50 mg by mouth every four hours as needed for pain.
Lunesta 2 mg as needed for insomnia.

ALLERGIES:
No known drug allergies.

SOCIAL HISTORY:
The patient was living alone and on disability without any illegal drug use but has come to us from [redacted] where he denies any alcohol use, although he has a history of alcoholism.

FAMILY HISTORY:
Family history significant for alcoholism in the mother with pancreatic cancer.

PHYSICAL EXAMINATION:
VITAL SIGNS: Temperature of 99.3, heart rate 110, blood pressure 153/102 with respiratory rate of 22, saturating 97% on trach collar 20%.

GENERAL: Confused, hallucinating, seeing smoke coming from the wall, but no apparent distress. Dry mucous membranes. Extraocular movement intact. PERRLA.
RESPIRATORY: Clear to auscultation bilaterally. No crackles. No wheezes.
CARDIOVASCULAR: Tachycardic but regular rate and rhythm. No murmurs, rubs, or gallop. Hickman on right chest, clean, dry, and intact.
ABDOMEN: Soft, nontender, nondistended, with a G-tube that is clean, dry, and intact.
EXTREMITIES: Warm and well-perfused with approximately four beats of clonus in both ankles bilaterally and tremulous legs.

LABORATORY DATA:
Complete Blood Count with WBC of 6.8, hemoglobin and hematocrit of 8.8 over 26.6, platelets 351, with 69.4% granulocytes. Basic Metabolic Panel was notable for a sodium of 140, potassium of 2.8, chloride 97, bicarbonate of 27, anion gap of 16, glucose of 101, BUN of 10, creatinine of 0.75, calcium 9.3, mag of 1.2, phosphorous of 2.6, albumin of 3, normal liver function tests, normal lactate, normal amylase, and normal lipase. Urinalysis shows specific gravity of 1013, large leukocyte esterase, greater than 100 WBC's and many bacteria. Influenza swab for influenza A and B was negative.

ASSESSMENT AND PLAN:
55-year-old male with a history of rhabdomyolysis secondary to a fall with development of end-stage renal disease and recent initiation on arctic sun protocol but now presenting from rehabilitation with altered mental status, fevers, and increased temperature and increased respiratory rate and increased heart rate found to have a urinalysis positive for leukocyte esterase with greater than 100 WBC's, consistent with a urinary tract infection.

PLAN BY ISSUE:
1. Infectious Disease. Urinary tract infection as most likely source. Will check chest x-ray. Send blood cultures. Follow up urine cultures. Previous urine grew Methicillin sensitive staph aureus so will continue ceftriaxone 1 gram intravenous every 24 hours and follow for speciation and sensitivities of culture.
2. End-stage renal disease. Hemodialysis Tuesday, Thursday, Saturday. Will consult Renal dialysis. Continue sevelamer 2400 mg three times daily.
3. Altered mental status. Could be secondary to infection. Will hold Ambien and other medications that may worsen delirium. The patient recently started on Lexapro. Will hold this as well.
4. Cardiovascular. Continue metoprolol 37.5 mg twice daily and Lisinopril 40 mg by mouth daily. We will check electrocardiogram. The patient is tachycardic and want to ensure that it is sinus.
5. Normocytic anemia. Most likely secondary to end-stage renal disease. Continue ferrous sulfate three times daily.
6. Psychiatric. Continue fluoxetine 60 mg by mouth daily.

7. Alcohol abuse. Continue folic acid 1 mg by mouth daily.
8. FEN. Follow up chest x-ray for G-tube placement that was done in the emergency room. Continue Protonix 40 mg by mouth daily. Replete potassium and magnesium as these could be causing tremors in the lower extremities. Continue tube feeds with Jevity 1.0 60 cc per hour times 18 hours.
9. Prophylaxis. Subcutaneous heparin for deep venous thrombosis prophylaxis.
10. Code status. The patient is a full code.

[redacted]

Signature Line
Electronically Signed by the following provider(s):
[redacted]
on 11/01/2012 01:17 PM EDT

DD: 10/31/2012 12:13 AM EDT
DT: 10/31/2012 09:47 AM EDT
TR: TMB

[redacted]

[redacted]

WATERBURY HOSPITAL
64 Robbins Street · Waterbury, CT 06708

INTERDISCIPLINARY PROGRESS NOTE

DISCIPLINES MD RN LPN HC SW PT OT ST RCP RD RPH PCC PA

DATE & TIME	DISCI-PLINE	PROBLEM(S) / GOALS / PLAN — PATIENT PROGRESS
10/30 9p		**PGY-1 Admission Note**
		CC: AMS
BDL		**HPI:**
		[redacted] is a 55yo male with a long history of alcohol abuse who was recently hospitalized here for an extended period of time after being found down, now sent in from ECF for AMS. Patient was admitted to ICU on 8/22 after being found down. He required arctic sun protocol and was started on hemodialysis owing to what was ultimately ESRD caused by rhabdomyolysis. His hospital course was notable for persistent fevers of unknown origin and tachycardia that, despite extensive infectious, inflammatory, malignancy (imaging) workup, were never explained. Additional features of hospitalization included C.diff infection, MSSA bacteremia, knee eschars requiring surgical debridement, and NSTEMI type II, as well as trach and G-tube placement. He was discharged 10/11 to [redacted] of Waterbury and they report he was stable until this past Sunday, when he began to develop mental status changes. He was sent to the ED here that day, where he was found to be hypokalemic and was returned to ECF. According to the referral report, his mental status has continued to decline since then – with patient being very confused and hallucinating. The ECF planned to embark on their own workup, but when he fell today they sent him in.
		On interview patient is very confused and hallucinating. He reported seeing smoke in the room, being in the parking lot, that he only experienced pain in the knees when driving, and other such non-sequiturs. As such the interview was not very informative, in terms of direct responses to medical questions. A review of systems was attempted but not completed successfully.
		PMH/PSH:
		Depression
		HTN
		ESRD
		OSA
		h/o pancreatitis, esophagitis, gastritis
		Alcohol Abuse
		FUO

[redacted]

WATERBURY HOSPITAL
64 Robbins Street · Waterbury, CT 06708

INTERDISCIPLINARY PROGRESS NOTE

DISCIPLINES MD RN LPN HC SW PT OT ST RCP RD RPH PCC PA

DATE & TIME	DISCIPLINE	PROBLEM(S) / GOALS / PLAN — PATIENT PROGRESS
10/30		**PH:**
qf		Not elicited
BDL		**SH:**
		Now in ECF; formerly lived alone; long time alcohol abuser; formerly worked in chemical manufacturing company
		Tobacco/Alcohol/Drugs:
		Former smoker; long history of alcohol abuse prior to recent hospitalization
		Home Meds: from ECF list ?
		Codeine promethazine cough syrup
		Menthol topical/cepacol
		Metoprolol 37.5mg q12h
		Lisinopril 40mg qd
		MVI
		Protonix 40mg qd
		Lexapro 10mg qam
		HSQ
		Albuterol INH
		Ferrous sulfate TID
		Sevalamer TID
		Flomax qhs
		Cymbalta 60mg qd
		Midodrine 10mg qd prn
		Zolpidem 5mg qhs prn
		Morphine 15mg q4h prn
		Allergies:
		NKA

WATERBURY HOSPITAL
64 Robbins Street · Waterbury, CT 06708

INTERDISCIPLINARY PROGRESS NOTE

[redacted]

DISCIPLINES: MD RN LPN HC SW PT OT ST RCP RD RPH PCC PA

DATE & TIME	DISCI-PLINE	PROBLEM(S) / GOALS / PLAN — PATIENT PROGRESS
10/30		**PCP:**
6p		[redacted]
		Contact:
BD		[redacted]
		Vitals: ~~98.1~~ F, ~~88~~ HR, ~~22~~ RR, ~~144/76~~ BP, ~~91%~~ O2 91% 1L
		99.8 115 22 160/90
		Physical Exam: 94 yo
		Gen: confused, hallucinating, stable
		HEENT: PERRL, EOMI
		Card: S1S2 ⊕, tachy
		Pulm: good air movement; rhonchi
		Abd: soft, non-tender; two healing ulcers c dry eschar
		Ext: ⌀ edema, ⊕ healing wounds on knees
		Neuro: 4/5 strength b/l, good finger grip
		Labs:
		6.8 > 8.8 / 26.6 < 357 ; 140 / 28 | 97 / 27 | 10 / 0.8 < 101 0.8 ; Mg - 1.2, Phos - 2.6, prot - 6.8, albumin - 3.0, bili - 0.9, AST - 24, ALT - 14, alk phos - 110
		U/A: large leuk est, WBC >100/hpf, many bacteria
		Imaging:
		CT Head (10/28): IMPRESSION: No acute intracranial process.

[redacted]

WATERBURY HOSPITAL
64 Robbins Street · Waterbury, CT 06708

INTERDISCIPLINARY PROGRESS NOTE

DISCIPLINES MD RN LPN HC SW PT OT ST RCP RD RPH PCC PA

DATE & TIME	DISCIPLINE	PROBLEM(S) / GOALS / PLAN	PATIENT PROGRESS
10/30		**A/P:**	
		[redacted] is a 55yo male with a long history of alcohol abuse, now with ESRD, FUO, tracheostomy, G-tube sent in from ECF for AMS, confusions, hallucinations. Workup largely unrevealing with the expection of hypokalemia, hypomagnesemia, U/A showing large leuk est and >100WBC/hpf.	
		AMS:	
		-likely secondary to urinary tract infection, given baseline cognitive deficits	
		-previous CT head neg	
		-other etiologies to consider are seizure, hypoxemia, drugs/meds (though unlikely given how closely he is monitored and how limited he is functionally).	
		UTI.	
		-3 out of 4 SIRS	
		-Ceftriaxone pending urine C&S	
		-f/u CXR, blood culture	
		Electrolyte abnormalities	
		-given hypoK – get EKG	
		-given spasticity and twitching would check ionized calcium	
		-monitor BMP; replete all lytes	
		ESRD	
		-HD T/Th/Sa	wound care
		-renal consult	
		- iron repletion	
		Psych	
		-cont duloxetine	
		FEN: pending G-tube	
		PPX: protonix, HSQ	
		CODE: FULL	

[redacted]

[redacted]

7019

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HOUSESTAFF MEDICAL TEAM PROGRESS NOTE

DATE 10/31/12

TIME 6AM

Overnight Events / Subjective:
NAE O/N

Fingerstick glucoses: Ø

Meds.
MVI 1 tab D'
Pantoprazole 40mg D'
Flomax 0.4mg D'
Sevelamer 2400mg TID
Metoprolol 37.5mg BID
Lisinopril 40mg D'
Folic Acid 1mg D'
Ferrous sulfate 325mg TID
Cymbalta 60mg D'
Albuterol neb TID
Vicodin PRN pain
Nystatin Powder to back TID

TempM:	TempC:	HR:	BP:	RR:	O2 Sat:
100	98.2	116 (95-116)	168/80 (149/68 - 153/102)	18 (14-22)	98% RA (Trach collar 4-20)

Relevant Physical
GEN Awake, A&Ox0
HEENT trach in place
RESP Lungs CTAD
CV: RRR
ABD S/NT/ND +BS
EXT: Ø edema

I/O:
I: 260
O: 2 urine, 1 stool

PRNs (past 24hr)
Ø

Relevant Labs/Imaging

CBC: WBC 8, Hgb 9.9, Hct 27.1, Plt 355

BMP: Na 144, Cl 100, BUN 10, K 3.3, CO2 26, Cr 0.75, Glucose 94

AG-15

Ca 3.3 / 1.4 / 2.7

UCx:
BCx:

Working Diagnosis/Current Plan:
55 yo M c hx of polysubstance s/p cardiac arrest + ESRD 2/2 rhabdo p/w rehab c fever, AMS + ↑RR c U/A c/w UTI. See Admission H+P for full H+P

ID: 3/4 SIRS criteria c source most likely urine infection
- F/u blood cx
- F/u urine cx
- Cont CTX 1gm IV D'
- F/u CXR

AMS
- Hold benzos, Ambien + seroquel
- Cont Cymbalta
- Treat infection

HTN
- Cont Lisinopril + Metoprolol

Anemia:
- Continue Ferrous Sulfate TID

ETOH Abuse:
- Cont Folic Acid 1mg D'

ESRD:
- F/u renal consult
- HD TTh+S
- Cont. Sevelamer 2400 TID

GI:
- Cont Protonix
- Cont tube feeds + free H_2O bids
- Nutrition consult

Resp.
- Cont Albuterol
- Cont humidified trach collar

Abx (Day#)
CTX 1gm IV D'

IV fluids.
Ø

Lines:
Hickman
PIV

Foley? Y (N)

Restraints? Y (N)

CODE	DVT prophylaxis:	Dispo:
Full Code	HSQ	

[redacted]

CN9213

[redacted]

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DATE & TIME	DISCIPLINE	PROBLEM(S)/GOALS/PLAN PATIENT PROGRESS
10/31/12	245P	Med Attending
		Pt interviewed & examined by me. Agree c history
		per [redacted]. Pt still currently unable
		to give a history given AMS. See their notes for
		HPI, PMH, SH, meds, allergies.
		Tm 99.3 TC 98 104-116 141-163/63-112 98% RA
		Gen in posey vest NECNT EOMI, I had must
		Neck: trach Lungs CTA Abd soft NTND NABS
		Ext ⊖ edema
		Labs WBC 8 K+ 2.8 on admission UA ⊕ LE/WBC
		A/P: ① AMS ? 2° to UTI - continue antibiotics & IVF
		② UTI - as above
		③ Hypokalemia - Cont repletion
		④ Trach - ask Pulm if this can be D/C'd
		All other plans per [redacted] note.
		[redacted]

CN4166 dr_odspro_modex dcl 7/97